23

Education and Counseling

"I came to the clinic for an injection. No one told me that Depo-Provera might cause changes in my monthly bleeding. It was a frightening experience because I didn't know what was happening. After it was explained to me that nothing was wrong, I felt much more comfortable."

Almost all family planning clients need information about child spacing and birth control methods. Many have questions. Nearly all will need instructions on how to use their selected method of contraception. Teaching facts and skills to your clients is called education.

Some clients also need counseling, which involves exploring the client's emotions and helping her solve problems. Women may need counseling on how to encourage their partners to accept family planning. If a woman has a sexually transmitted infection (STI) or an abnormal laboratory test, she will need counseling to help her manage the situation and decide what to do.

Good education and counseling require good communication. How the provider talks to the client can sometimes mean the difference between whether the client is a successful user of family planning or an unsuccessful one. The important elements communication should cover during a family planning visit may be remembered by the word GATHER[2]:

G	Greet clients in a friendly and helpful way
A	Ask clients about their family planning needs
T	Tell clients about available family planning methods
H	Help clients decide which method they want
E	Explain how to use the method chosen*
R	Return visits should be planned

*(see the BRAIDED list later in this chapter)

In addition to following these general suggestions, the provider should remember the following definitions:

- *Education*—The skills and knowledge family planning clients need to make informed decisions and to use their chosen contraceptive methods successfully. Teaching about specific contraceptive methods should include the basic elements described in the word BRAIDED, which is discussed later in this chapter.
- *Counseling*—The help clients need to overcome obstacles posed by lifestyle, life situations such as a partner who is not supportive, or fears grounded in misconceptions.

PRINCIPLES OF EDUCATION

In many parts of Africa, few women are formally educated beyond the early grades. Thus, few women know much about anatomy, the reproductive cycle, or the facts of family planning. Clients generally already have some information about family planning methods that they obtain from family and friends or from their own experience. Their information may be accurate, or it may be dangerously wrong. The provider's responsibilities include helping correct inaccurate information, which is often based on popular myths about contraception.

The following principles, which are based on ways in which adults learn, can be useful in the family planning clinic:

- Allow time for the client to discuss her questions and concerns. Some clients need a lot of encouragement to ask questions.
- Involve the client actively. The client learns from what she does, not from what the provider does. Have her touch and handle birth control methods; role play, if necessary. Make sure the client understands by asking her to repeat the directions in her own words.
- Teach with stories and examples. Abstract ideas are grasped more easily when presented in a human context. For example, compare two couples, one using birth control and the other experiencing an accidental pregnancy. Use simple hand puppets to act out small dramas.
- Be gentle in manner and technique. People learn best when they feel safe and calm. A person coming for a medical examination rarely feels safe and calm.
- Anxiety and disappointment interfere with learning. People who learn they are pregnant when they do not want to be, have a sexually transmitted infection (STI), or are worried about some aspect of their health often say they remember little you say beyond hearing their test result is "positive" or "negative."
- The average person understands and remembers about three messages at one time. Think about the few most important facts the client must know and teach her those. Almost no client can learn *all* she needs to know in one visit. Invite her for a group session; provide take-home materials she can understand; schedule another visit if needed. (See Table 23:1.)

  Remember:

  — First things first. What's most important?
  — Keep it simple. Use words clients understand.
  — Keep it short. Do not confuse the client with too much information.

— Be specific. Do not say "Take your pills on time." Instead say "Take your pills every morning after breakfast or pick another time that is better for you."

— Say it again. Repeat the most important instructions.

- Give factual, unbiased information about the various birth control methods. The word BRAIDED can help you remember what to talk about when you teach clients about *specific* methods:[3]

B Benefits of the method

R Risks of the method (both major risks and all common minor ones), including consequences of method failure

A Alternatives to the method (including abstinence and no method)

I Inquiries about the method are the client's right and responsibility

D Decision to withdraw from using the method without penalty is the client's right

E Explanation of the method is owed the client

D Documentation that the provider has covered each of the previous six points

Table 23:1 Education programs in family planning settings

• Teach group classes
• Educate and counsel individual clients
• Present 10- to 20-minute audiovisual programs
• Display posters
• Hand out materials (written and pictorial)
• Set up libraries and reading areas
• Demonstrate the use of birth control methods on life-like models
• Evaluate client learning through question and answer sessions

Consult Chapter 11 on the Essentials of Contraception for summaries of important information you can use in discussions with clients about the advantages and disadvantages of contraceptive methods and instructions for using them.

PRINCIPLES OF COUNSELING

Family planning decisions often come from the heart. How to select when to have a baby, how many children to have, and what contraceptive method to use are often emotional choices. Clients facing family planning decisions may have intense feelings of anger, anxiety, fear, disappointment, or even joy. Although the provider can offer facts to help the client choose, the provider must also acknowledge and discuss the client's feelings as well.

Determine what each client is feeling about the things you are discussing.[5] For example, say "Yes, you are pregnant. Can you tell me how this news feels to you?"

- Do not make decisions for the client. The best response to "What do you think I should do?" is "What do you think? I will help you think about the positive and negative issues."
- Listen. Often, clients need to be understood more than they need anything else.
- Open-ended questions uncover more about the client than closed questions that need only a yes or no response.
- Avoid asking "why" questions. "Why" questions are usually difficult or impossible to answer. Clients can feel threatened by having to answer "why."
- Help preserve hope, even in the face of a terrible illness such as the acquired immunodeficiency syndrome (AIDS).
- Be honest.

Cultural values and ideas learned in childhood strongly influence each person. Cultures vary widely in their attitude toward reproductive lives. Care providers need to know the cultural values of the client population and should learn, for example:[9]

- The ideal family size
- Who makes sexual decisions
- The typical marriage age
- How the culture understands the causation of unintended pregnancy or illness
- Who the powerful healers are
- What the client considers safe to tell the care provider
- How the husband (or wife) will respond to your care
- Whether the cultural communication style is direct or indirect or formal or informal

Balance your understanding of each client's unique personality with an awareness of and respect for influential cultural values and characteristics.

At the family planning clinic, Mrs. K asked for some way to give her space and a rest between pregnancies. She had not asked her husband for permission. However, he learned of her actions and said he would divorce her if she continued using contraception. She stopped and soon became pregnant.

In many cultures, women often are not given the authority to make the decision to practice family planning. In sub-Saharan Africa, there are still many women who do not seek more children but who do not use contraception because they believe their husbands oppose it.[1] (See Chapter 11 on Essentials of Contraception.) However, more than half of women who report their husbands disapprove of family planning have never even discussed family planning with them.[1] These women need to know how to initiate nonthreatening discussions with their husbands, then select methods that would suit the couple's relationship.

Conversely, men need education about the benefits of family planning. They need to learn that modern contraception will not harm them, their wives, or their children. In some cases, providers will need special help in dealing with husbands, such as when a woman

faces serious consequences from her husband if she makes family planning decisions on her own. A village leader or wise man, a religious leader, a respected elder, or a relative may help by talking with the husband and helping him understand the benefits of a planned family. (See Chapter 1 on the Benefits of Family Planning.) Situations in which a client's spouse is opposed to family planning are difficult for both the client and the provider. Solutions are more likely found if the providers can gain the support of their clients' communities.

PRINCIPLES OF BEHAVIOR CHANGE

Not all clients are equally ready to undertake changes in their daily lives that will promote their personal health, such as abstaining from sex or using condoms when there is a risk of STI, stopping smoking, or taking birth control pills. However, the health care provider can help the client move along a continuum, progressing from no change to little to moderate to complete change. Because change is incremental, interventions must be tailored to the client's particular position along a continuum of change.[6] Scientists have described five steps along the behavior change continuum,[7,8] which are detailed in Table 23:2.

In individual counseling, asking one or two questions ("What are you doing to protect yourself from accidental pregnancy?" "When would you like to become pregnant?") can help place the client along the stages of change continuum. Then, you can use the limited time available for education more effectively.

People change behaviors as a result of acquiring a new skill more often than as a result of gaining new knowledge. In teaching new skills, adapt the intervention to the client's own readiness for change.

Setbacks are common with any attempt to change human behavior. Clients whose behaviors slip back to an earlier level will need extra help with renewed (and perhaps re-thought) goal setting, a boost in self-esteem, and sympathetic understanding.

Table 23:2 Stages of change and educational interventions

Stage	Characteristics	Typical response to "What do you do to protect yourself from AIDS?"	How to focus educational intervention
Precontemplative	Not aware of risk, denies risk, no plan to change	"Who me?"	Teach risk awareness facts, show models of desired behavior
Contemplative	Thinking about change, no specific plans	"I've been thinking about that myself"	Assist with priority-setting, teach skills required for change, promote self-efficacy, ("You can think for yourself.")
Ready for action	Has a plan, some action steps	"I checked out condoms in the drugstore the other day. There must be 30 brands!"	Assist with personal goals, reinforce skills, promote self-efficacy
Action	Change has begun, change is new	"From now on, no sex without condoms! Got them here in my pack!"	Reinforce personal goals, promote self-efficacy, show models of desired behavior
Maintenance	Change is in place, change is sustained	"I haven't had sex without condoms in a year now."	Praise success, promote self-efficacy, show models of desired behavior

Sources: O'Reilly and Higgins (1991); Prochaska and DiClemente (1983); Prochaska and DiClemente (1984)

REACHING CLIENTS

Because many African women have only limited reading skills, educational materials need to be designed that will be suitable for such an audience. Educational materials can be made more interesting, relevant, and motivating if they use stories, especially because Africa has a great tradition of storytelling.

In print materials, the text should use simple words, short sentences, and as many pictures as needed to communicate the message. Print materials in many forms are appropriate, such as pamphlets, flyers, letters, posters, and newspapers.

For many women, the spoken word is more effective. Classes, group meetings, or messages given during entertainment can get the information across. A number of nations have found that radio broadcasts are very helpful in reaching both women and men. Although rural populations are often targeted, people who live in urban areas also can benefit from radio broadcasts. Examples of radio dramas broadcast in four African countries are presented in Table 23:3.

Table 23:3 Main characters and plots of radio dramas in four countries

Program	Main characters	Plot
"Akumwera Nechekuchera" (Zimbabwe)	Jonasi Musekiwa and his two wives; Herija, Jonasi's best friend and coworker; Mbasera, a city friend of Jonasi's; and Chigwande, a rural health worker.	Jonasi, who works in the city, struggles to support his 15 children home in the village. Herija encourages Jonasi's spendthrift ways and extra-marital affairs, while Mbasera urges him to be more responsible.
"Ezi na Uno" (Nigeria)	Emeka and Nneka, a married couple satisfied with four children; Emeka's mother; and Obiageli, the woman Emeka's mother wanted him to marry.	Emeka's mother demands more grandchildren, and Obiageli (already the mother of seven, but with marital difficulties) tries to win Emeka back by offering to bear him children.
"Fakube Jarra" (Gambia)	Fakube Jarra, a local wise man; Fa Abdou and Mba Kujay, a monogamous couple with three daughters; Jainaba, Fa Abdou's widowed sister; and Fa Mamodou and Mba Hawa, a polygamous couple with six sons.	Jainaba and Fa Mamodou both have difficulty supporting their families but try to convince Fa Abdou that he should have more children. Fa Abdou seeks advice from Fakube.
"Family Affair" (Ghana)	Obo and his two wives, Adodo and Kawe; Adodo's mother; and GideeGidee, a witch masquerading as a traditional healer.	Kawe tries to introduce modern hygiene into the household, but jealous Adodo and her mother assume Kawe's motive is to monopolize Obo's attention.

Source: Lettenmaier (1993)

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